Physicians: please

especially

PLAINLY

WRITE

PLEASE

Address

(Date rec'd by registrar)

correct

carefully. clearly and

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

Injured at work?

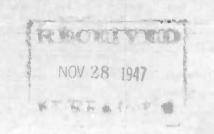
M. D. or other

Date signed.....

CERTIFICATE OF DEATH 1. PLACE OF DEATH: 2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother) State (If outside city or town limits, write RURAL and give nearest town) How long in above place of death?..... (If outside city or town limits, write RURAL and give nearest town) Hospital, institution, or street address where death occurred: (If rural, give LOCATION) How long in hospital or institution?. 3. (a) FULL NAME 3. (b) Social Security Number 5. Color or raca 4. Sex CERTIFICATION CERTIFY that death occurred on the date above stated: that I attended deceased from 7. Birth date of deceased (mo., day, yr.) DURATION 8. AGE: (Town, county, and state) 1D. Usual occupation 11. Industry or business 13, Birthplaco (Include pregnancy within 3 months of death) Major findings of operations..... 15. Birthplace 16. Informant PHYSICIAN: Please underline the cause to which death should be charged statistically. 22. VIOLENCE: If death was due to external causes, fill in the following: Accident, suicide, or homicide..... (Burial, cremation, or removal, Which (moath) (day) (year) Where did Injury occur? (City or town) (County) (State) Injured at home, farm, industry, public place (where?)

Means of Injury

Registrar



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

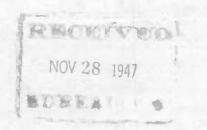
CERTIFICATE OF DEATH

1. PLACE OF DEATH: County City or town. (If outside eity or town limits, write RORAL and give nearest town) How long in above place of death? Hospital, institution, or street address where death occurred: Now long in hospital or institution?	2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother) State County County City or town Office of the county
3. (a) FULL NAME Walter Brooks.	3. (b) Social Security Number
4. Sex 5. Color or race 6.(a)Single, married, widowed, or divorced	MEDICAL CERTIFICATION 20. DATE OF DEATH
6.(b) Name of husband or wife In an Cer Brooker	21. I CERTIFY that death occurred on the date above stated; that I attended decessed from
7. Birth date of see and see a	and that I last saw h. alive on
8. AGE: Years Months Days If less than one dayhrsmln.	Immediate cause of death DURATION Oronary Ordingon
9. Birthplace Md (Town, county, and state) 10. Usual occupation Laker of the latest occupation occupa	Due to. Due to. Due to. Due to. Due to. Diher conditions.
13. Birthplace may 14. Maiden name Dissie Wall 15. Birthplace md 16. Informant Lewes Broke	(Include pregnancy within 3 months of death) Major findings of operations. Dale of op. Autopsy results. PHYSICIAN: Please underline the cause to which death should be charged statistically.
Address Prince Frederick, mag 17 Burial Date thereof 11-22, 47 (Burial, cremation, or removal, Which?) Cemetery or crematory 21 + Olive	22. VIOLENCE: If death was due to external causes, fill in the following: Accident, suicide, or homicide
Location Calvert 18. Funeral director P. E. Devell Address Prance Frederichus 19. 11-21 18 47 H.W. Ward (Date rec'd by registrar) (Date rec'd by registrar)	Injured at home, farm, Industry, public place (where?) Maans of Injury Linjured at work? 23. SIGNATURE M. D. or other Address S. A. Reman, M. D. or other M. D. or other Address S. A. Reman, M. D. or other M. D. or other Address S. A. Reman, M. D. or other M. D. or other

WRITE PLAINLY, WITH CANFADING INK. Supply every item of information carefully. Ine is especially important. Physicians: please write the causes of death clearly and legibly

PLEASE

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

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CERTIFICATE OF DEATH

Reg. Dist. No....

1. PLACE OF DEATH:	2. USUAL RESIDENCE (HOME) OF DECEASED:	
County Calvert County	(For newborn fights gift rysidence of mother)	1.
City or town	State. Company Tank District Company	
How long in above place of death?	City or town	arest town)
Hospital, inetitution, or street address where death occurred:		
Calvert County Hospital	Streef No	***********
How long to hospital or institution?	2.(a) If veteran, name war	***************************************
3. (a) FULL NAME	3, (b) Social Security	Number
me Robert E. Dennison		
4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced	MEDICAL CERTIFICATION	
male whose widowed	W ~ 1, 10 C:	7 61-1-15
male white widowed	2D. DATE OF DEATH	at B J J A
6.(b) Name of husband or wife	21. I CERTIFY that death occurred on the date above stated; that I attended dece	
R (A) If alive vive aga vage	Moresulle > 19 47, 10 Mores	Well 5 19 7
7. Birth date of deceased (mo., day, yr.)	and that I last saw h. West alive on MMM 15	19
deceased (mo., day, yr.) 8. AGE: Yeare Months Daye If less than ooe day	Immediate cause of death.	. DURATION
6. Add.	Cuella Nemosslage	0.0
68 3 //hrsmin.		***
8. Birthplace WAShingTon DC	Due to	
(Toyn, county, and state)		**
10. Usual occupation	Due to	
11. Industry or businese		
12. Name William & Dennisan 13. Birthplace Warls D. C	Other conditions	*
13. Birthplace Wash D. c	(Include pregnancy within 3 months of death)	
14 Maiden name Flora Cook		
5 11. A D A.	Major findings of operations.	
E 15. Birthplace Wash, U.C.		••••••••••
18. Informact (M.1.8) P. C. L. M. M. S. S. M.	Autopsy results	
Addrees / 701 - 16 st NW, 11		statistically.
17. (Burial, cremation, or removal, Which?) Date thereof Wow 18, 1947 (month) (day) (year)	22. VIOLENCE: If death was due to external causee, fill in the following:	
(Burial, cremation, or removal, Which!) Bate fhereof (month) (day) (year)	Accident, suicide, or homicide	
Cemetery or crematory Qalt Itel Chueling	Where did injury occur?	(State)
Location Work D.C.	Injured at home, farm, industry, public place (where?)	
0 4 4 2 62 5	freams of injury injured at work?	
19. Funeral director.	0. 000	
Address Walsh, D.C.	age 1500	
10 11-16 10 47 W. W. Wars	23. SIGHATORE M. D.	or other
(Data ree'd by registrar)	Address HIMI NERVICE Date signed.	

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MEDICAL COCUME AND INCHES

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct is especially important. Physicians: please write the causes of death clearly and legibly.

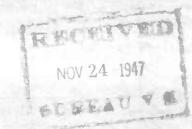
MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

1. PLACE OF DEATH:	2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)	
County Calse at Coursely	State May land county Cols	meet
City or town	01 - 7 1	u h
How long in above place of death?	Cily or towo(If outside city or town limits, write RURAL and	give nearest town)
Calvert Co. Hospital	Sireet No. (If rural, give LOCATION)	***************************************
How long in hospital or institution? 2	2.(a) It veteran, name war	
3. (a) FULL NAME	3. (b) Social S	ecurity Number
Halle Hal		
4. Sex 5. Golor or race 6.(a) Single, married, wildowed, or divorced	MEDICAL CERTIFICATION	N
temple Coloud	20, DATE OF DEATH	47 at 2:32 F
6,(b) Name of husband or wite	21. I CERTIFY That death occurred on the date above stated: that I atter	
	19. 7.7. , to	
1. Birth date of deceased (mo., day, yr.) April 10 - 1896	and that I last saw h A. alive on	19
8. AGE: Years Months Days It less than one day	Immediate cause of death	DURATION
51 1 7min.	Che respondella	
9. Birtholace Underson	Due to	
(Town, county, and state)		
tD. Usual occupation	Due to allowellow	
11. Industry or business		
12. Name Loss Hall 13. Birthplace Whenver	Diher conditions	0.0000000000000000000000000000000000000
MI 000 L 0 11	(Include pregnancy within 3 months of death)	
14. Malden name. Management de la	Major findings of operations	
1 15. Birthplace Antanova	Date of	Dp
16. Informant The Third Th	Antopsy results	charged statistically.
Address // suchelvelle . Total	22. VIOLENCE: If death was due to external causes, fill to the following	ng;
(Burial, cremation, or removal. Which?) Bate thereot (nonfn) (daf) (year)	Accident, suicide, or homicide	ot
Complety or crematory FRIENDSHIP	Where did injury occur?(City or town) (County)	(State)
Location FRIENDSHID, Md	Injured at home, farm, industry, public place (where?)	
18. Funeral director, T.A. Herdes ty45on	Means of Injury Injured at w	ork?
Address Fales VIII Met	QV -	
11 15 15 11 11 11	23. SIGNATURE	M. D. or othar
19	Address Friedlinghows Date	signed ///9/4/2

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

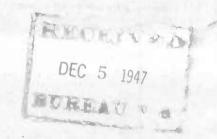
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09864

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH. County	2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother) State
3. (a) FULL NAME James Um Han	3. (b) Social Security Number
4. Sex 5. Color or race 8.(a)Single, married, widowed, or divorced	20. DATE OF DEATH 26. 26. 1967, at 1.3 25. M. 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
6.(c) Name of husband or wife 6.(c) If alive, give age years 7. Birth date of	and that I last saw b
deceased (mo., day, yr.) 8. AGE: Years Months Days If less than one day	Immedial cause of death DURATION Commonweal Succession
9. 9irthplace	Due to
12. Name	Other conditions
14. Malden name July 15. Birthplace	Major findings of operations. Date of op.
16. Informant Audit Auditans	Autopsy results
17. Burial Oate thereol (month) (day) (year)	22. VIOLENCE: If death was due to external causes, fill in the following: Accident, suicide, or homicide
Cemetery or crematory. Complete. Location Calvert	Where did Injury occur?
18. Funeral director. P. E. Perrale Address Prince Frederich	Meens of Injury Injured at work?
18. 11-28 19 47 Nw. ward. (Date ree'd by registrar) (Date ree'd by registrar)	Address Daving Date signed L1/26/4.7



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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

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Reg. Dist. No....

CERTIFICATE OF DEATH

1. PLACE OF DEATH:	2. USUAL RESIDENCE (HOME) OF DECLASED: (For newborn infants give residence of mother)		
no the med	State Maryland County Calcut.		
(If outside city or town limits, write RURAL and give nearest town)	City or town Olivett		
How jong in above place of death?	(If outside city or town limits, write RURAL and give nearest town)		
Hospital, institution, or street address where death occurred:	Street No		
	(If rural, give LOCATION)		
How long in hospital or Institution?	2.(a) If veteran, name war		
3. (a) FULL NAME Rachel a Hallis.	3. (b) Social Security Number		
4. Sex 5. Color or race 8.(a)Single, married, widowed, or divorced	MEDICAL CERTIFICATION		
F C X.	20, DATE OF DEATH		
6,(b) Name of hysband or wife	21. I CERTIFY that death occurred on the date above stated; that I attended deceased from		
7. Birth date of	and that I fast saw halive on		
8. AGE: Years Months Days If less than one day	Immediate cause of death		
o. AGE:	Cartral entrelism		
63min.			
9. Birthplace (Town, county, and state)	Due to.		
10. Usual occupation Domestic	Cosatial hyperlaning		
10. Usual occupation	Due to.		
11. industry er business	allens Flower		
12. Name mathew Sutton.	Other conditions		
13. Birthpiacs	(Include pregnancy within 3 months of death)		
14. Maiden name Sarah Johnson.			
0	Major fiedings of operations.		
16. Informant Pita Sutton	Autopsy results		
Address Olivett, md,	22. VIOLENCE: If death was due to external causes, fill in the following:		
(Burial gremation or removal Which?) (Burial gremation or removal Which?)			
	Application of the state of the		
Cemetery or crematory Eastern Chapel	Whers did Injury accur?		
Location Calvert, Co,	Injured at home, farm, industry, public place (where?)		
18. Funeral director Pt. Sewell	Means of injury Injured at work?		
Address Prince Frederick, Md	(Viltourent)		
1.1	23. SIGNATURE M. D. or other M. D. or other M. D. or other		
19. (Date ree'd by registrar) 19. 47. (V-U) Cward Registrar	Address Date signed how My		

NOV 20 1947

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

Reg. Dist. No.

CERTIFICATE OF DEATH

1. PLACE OF DEATH:	2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
County Colored	
City or town	State Maryland County Colors
	City or town
How long in above place of death?	(If outside city or town limits, write RORAL and give heatest county
Hospital, Institution, or street address where death occorred:	Street No.
	(If rural, give LOCATION)
How long in hospital or institution?	2.(a) 11 veteran, name war
3. (a) FULL NAME	3. (b) Social Security Number
WILLIAM - HE-KOPP	
4. Sex 5. Color of race 6.(a) Single, married, widowed, or divorced	MEDICAL CERTIFICATION
male Mute morried	20, DATE OF DEATH NEVERNLEY - 3 197 , at 6 P
6.(6) Name of hubband or wite MAUD - KOPP.	21. I CERTIFY that death occurred on the date above stated; that I altended deceased from
C (a) to allow price and	July 19 15 10 Nov. 3 1974
7. Birth dale 01 Section 2 196	and that I last saw h M alive on NSU = 3 - 19.
deceased (mo., day, yr.) Lovenv 46 - 7000	Immediate cause ni death
8. AGE: Years Months Days It less than one day	
80 11 7hrs	Chrones Myscardeles 3900
Is more maruland	
9. Birthplace	Serile degeneration
18. Usual occupation Corpletter	Bue to.
1t. Industry or business Shiftigand	BUC LUMINATION OF THE PROPERTY
12. Name Wilhelting Kapp 13. Birthplace Darmstadt - Germany	Other conditions
	(Include pregnancy within \$ months of death)
14. Maiden name arstine Darthe -	Major findings of operations.
14. Maiden name arstine Bartle -	
15. Biringiacy O WOTO LEW 15 & C	Date of op
16. Informant Color (16)	Antopsy results
Address Aslomons, mary are	
B Mad 10.15	22. VIOLENCE: If death was due to external causes, fill in the following;
(Burlal, cremation, or removal, Which?) (Burlal, cremation, or removal, Which?)	Accident, suicide, or homicide
Parto Comotos	Where did injury occur?
Cemetery or crematory and the contract of the	
Location Dallemon - Mary Rus	injured al home, larm, Industry, public place (where?)
10 Sweet director a. a. de darkoners i son	Means of injury tojured at work?
18. Funeral director.	C 0 0 - 1 m 10
Address Millia - Masyland	23 SIGNATURE E. S. Coster - M.W.
Draw. 3 47 Dr.6.8. (asto)	M. D. or other.
(Date rec'd hy registrar) Registrar	Address Date signed Bate signed



MARYLAND STATE DEPARTMENT OF HEALTH

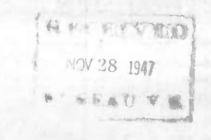
2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

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_	-	0.7		26.1.1

CLRITICAL	Reg. Diat. No.
1. PLACE OF DEATH: Calvert	2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
City or town	State Mary and County Collect. City or town Collect County Collect. (If outside city or town limits, write RURAL and give nearest town) Street No.
How long in hospital or institution?	(If rural, give LOCATION) 2.(a) If veteran, name war
3. (a) FULL NAME Amarida Ray (Car	3. (b) Social Security Number
4. Sex 5. Color or race 6.(a)Single, married, widowed, or dworced	MEDICAL CERTIFICATION 20. DATE OF DEATH
B.(b) Name of husband or wife	21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
7. Birth date of	and that I last saw h
deceased (mo., day, yr.) 8. AGE: Years Months Days If less than one day	Immediais cause of death DURATION Orteriosclesses
//hrsmin.	Cardias disease
9. Birthplace	Due to
10. Usual occupation	Due to
12. Name	Dther conditions
13. Birthplace H. Maiden name. Dinnie Chase. 15. Birthplace Md.	(Include pregnancy within 3 months of death) Major findings of operations
El 15. Birthplace	Date of op.
16. Informant The Company of the Com	Autopsy results PHYSICIAN: Please underline the caose to which death should be charged statistically.
Address 17. Barrial Date thereol (month) (day) (year)	22. VIOLENCE: If death was due to external causes, fill in the following: Accident, suicide, or homicide
Cemetery or crematory St Johns.	Whers did Injury occur?
Location Calvert	Injured at home, farm, Industry, public place (where?)
18. Funeral director	23. SIGNATURE PARE DE ST
(Date rec'd by registrar) (Date rec'd by registrar)	Addre Dunge Dederick Date signed // 2 4

WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. 9.45.15 PLEASE A15 S



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MARYLAND	STATE	DEPARTMENT	OF	HEALTH	.7
	2411 N. CH	narles St., Baltimor	0	45	-

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09868 Reg. Dist. No. 50

1. PLACE OF DEATH: Caly Cr.X	2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
Cily or town	State New County County
How long in above place of death?	City or town (If outside city or town limits, write RURAL and give negrest town)
Hospital, Institution, or street address where death occurred:	Sireet No. (If rured, give LOCATION)
How long le hospital or institution?	Z.(a) If veteran, name war 100
3. (a) FULL NAME Murray C. Rosentha	3. (b) Social Security Number
4. Sex 5. Color or race (6.(a) Single, married, widowed, or divorced	MEDICAL CERTIFICATION 13
male mute married	26. DATE OF DEATH MOVEMBER 20 1947, at 4-PM
6.(6) Name of Mustand or wife Mulchard Rosentles	21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
7. Birth date of	and that I last saw halive on
deceased (mo., day, yr.) Aug / U - / 8 7 /	Immediate cause of death DURATION
8. AGE: Years Months Days tt less than one day	
36 4 /	Caralac Disease:
9. Birthplace. Meld (Town, county, and state)	Due to.
10. Usual occupation Sociony owner - Dresses	Due to SM NOTE - (Ornice)
1t. Industry or business	from new york going to
12. Name Mycheal asterthal 13. Birthplace Roumania	Diher conditions Florida
	(Include pregnancy within 3 months of death)
14. Maiden name Caroline Wasserman 15. Birthplace Roumanna	Major findings el operations
3 15. Birthplace Councante	
18. Informant Tawara Caroal III	Antopsy results
Address 1449 - 6.26 - Proposition (104)	22. VIOLENCE: It death was due to external causes, till in the tollowing:
(Burlal, cremation, or removal. Which;) Date thereot (May) (724-194) (month) (day) (7ear)	Accident, suicide, or homicide
Cemetery or crematory washington Cemetery	Where did Injury occur?
Location Brooklesn - new yorks	Injured at home, tarm, industry, public place (where?)
18. Funeral director a. a. Starkness Son	Means of Injury Injured at work?
Address, Mulual - Maryland	Dr. E. S. Coster
11/20/47 A.E. B. (Voston).	23. SIGNATURE M. D. on/other
(Date rec'd by registrar) Registrar	Address Domono () Date signed / T



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